County Medical Services Program
Newsletter
Prepared by: AmeriChoice
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CMS Provider Survey

AmeriChoice conducted the annual Provider Survey in July of this year to solicit providers' opinions about the service they receive from the CMS Program. This survey allows AmeriChoice to examine procedures as viewed by the provider. Recommendations to investigate and improve processes are formed based on these results.

Surveys were sent to practitioners, and office billing staffs at Community Clinics, hospitals, specialty offices and ancillary providers. The return rate equaled 19 percent with specialty offices returning 35 percent; clinics and ancillary providers, 16 percent each and; hospitals, eight percent. The replies were then distributed by the type of position: administration and business managers, 33 percent; physicians, 25 percent; clinical staff, 24 percent and; billing staff 18 percent.

The survey questions covered ease in verifying eligibility, the processes for referrals, appeals, claims and payments. A group of questions also asked the respondent to rate their knowledge of CMS operations.

When all categories were combined 88 percent of those surveyed indicated they were very satisfied to satisfied with the services they received during the past year. All categories showed an increase with service satisfaction over the past three years. Provider understanding of CMS operations remained stable with increases in understanding the eligibility and claims processes.

Recommendations resulting from this survey include:

1. Continue education and outreach to hospital staff
2. Expand communication and education to primary care practitioners
3. Evaluate the TAR notification system
4. Evaluate the Claim notification system
5. Expand educational efforts regarding the appeal process.

Thank you to all who participated in this important activity

Scabies

This common skin infection is caused by the mite, Sarcoptes Scabiei. Scabies is more prevalent in urban areas, affecting women and children more often and more common in winter than in summer. Diagnosis is based predominantly on history and examination. Intense itching that is worse at night but spares the face and head are the pertinent historical elements. Lesions are noted usually over the flexor aspects of the wrists, in the finger webs, elbows, axillae, buttocks, genitalia, and the breasts of women. In an area of high scabies prevalence, (13% in sub-Saharan Africa) the complaint of diffuse itching with visible lesions along with the presence of either a household member with itching or the presence of two typical locations of scabies had 100% sensitivity and 97% specificity for scabies infection. This study has not been done in areas with lower prevalence.

Definitive diagnosis rests on identification of mites, eggs, eggshell fragments or mite pellets derived from skin sampling. Multiple superficial skin samples should be obtained from lesions in characteristic areas by scraping laterally across the skin with a blade, taking care to avoid bleeding. The number of scabies mites in common infections (5-15) make this diagnostic technique highly operator dependent. Failure to find mites does not rule out scabies.

Treatment should include infected persons and close physical contacts. All should be treated at the same time even in the absence of symptoms. The incubation period is generally three to six weeks for primary infections but may be as little as one to three days in cases of reinfestation. Permethrin and lindane are the two main therapeutic options. Both have been shown to be clinically effective with permethrin providing a 91percent cure rate at four weeks and lindane with an 86 percent cure rate. Permethrin has been noted to be safer with regard to neurotoxicity associated with multiple exposures to lindane and is recommended as first line treatment by the CDC. Oral treatment with ivermectin has been assessed but is only 70 percent effective in comparison to a 98 percent cure rate with permethrin. Efficacy of ivermectin was increased with a second dose taken two weeks later, but this entails issues of compliance and follow-up in comparison to the single application of a topical therapy. Patients should be advised that itching may persist up to four weeks following successful and curative treatment of an infection while shedding of the burrowing mites and eggs continues. Along with treatment of the individual and contacts, clothes and bed linens should be machine washed in hot water (60° C.) and machine dried as well. These would be the items that have been in contact with the patient over the past 48 to 72 hours only. Objects that cannot be washed and dried can be sealed in plastic for 48 to 72 hours since the mites cannot survive off the human body for this period.

Chosidow, O. (2006) NEJM 354(16): p1718-27.

CMS Formulary Changes In 2006

Generic Name	Brand Name	Strength	Action
Antidiabetic			
Insulin glulisine Insulin detemir Human insulin inhalation powder	▪ **Aprida** ▪ **Levemir** ▪ **Exubera**	100U/ml 100U/ml 1mg & 3mg packages	Code 1 for Project Dulce and endocrinologist. Quantity Limit (QL) 2 vials per month No QL for Exubera
Pioglitazone	**Actos**	All	PA required after 11/30/06: Avandia is preferred agent
All other insulins			Quantity limit of 2 vials per month
Steroid Inhalers			
Beclomethasone	▪ **QVAR**	All	Added as preferred agent
Proventil HFA	▪ **Albutarol HFA**		Code 1 for product shortage
Budesonide Fluicasone Triamcinolone	▪ **Pulmicort** ▪ **Flovent & HFA** ▪ **Azmacort**	All	Medical justification required: defer to preferred agent
ACE Inhibitors			
Benzapril Enalapril	▪ **Lotensin** ▪ **Vasotec**	All	Added to Formulary
Narcotics			
Morphine Sulfate Methadone Sulfate	▪ **MS Contin** ▪ **Methadone**	All	Added to formulary with Quantity Limit of 100/mo
Tramadol	**Generic only**	50 mg	Added to formulary with Quantity Limit of 150/mo
Note: PA requirements are no longer required for maximum quantities of one long acting and one short acting narcotic each month			
Neuroleptics			
Pregabalin Oxcarbazapine Tiagabine	▪ **Lyrica** ▪ **Trileptal** ▪ **Gabitril**	All	Prior authorization required. Contingent therapy of T/F tricyclic agents, carbamazepine and gabapentin. Quantity limits of 60 tabs/mo; 1,200ml/mo
Neurontin Gabarone	▪ **Gabapentin**	All	Contingent therapy: T/F tricyclic agents and carbamazepine. Quantity limit of 120/mo

Authorization Requests

In its effort to assure quality customer service, the AmeriChoice Medical Management Department has been tracking the Treatment Authorization Request (TAR) turn-around-time for the past 12 months. The treatment goal is to have non-urgent TARs processed within 7 business days of receipt and urgent TARs processed within 1 business days of receipt. In any given month, the Medical Management Department receives approximately 2,000 referrals; the majority of which arrive by facsimile. The monitoring process begins from the date the TAR request is received in office through to the date the determination has been made and the provider(s) have been notified. The results consistently are as follows:

Non-urgent TARS

99 percent within 5 days
78 percent within 2 days

Urgent TARs

99 percent within 1 day

Questions regarding the TAR process should be directed to the Medical Management Services Manager at 858-495-1314.

CMS Documents On-Line

www2.sdcounty.ca.gov/hhsa

For Provider Handbooks, CMS Formulary and Quick Reference Formulary	▪ Click on "Programs" ▪ Select "Self Sufficiency Programs" ▪ Click on "View All Services" ▪ Scroll down to CMS and select the document
For CMS Forms and Worksheets (TAR Form, UPC Voucher, Work Histories, Sleep Study, Incontinence, Pulmo-Aide, and Hepatitis C)	▪ Select "Documents" (left side of the screen) ▪ Select "Forms" from the drop down box ▪ Scroll down to CMS and select the form
For Provider Newsletters	▪ Select "Documents" (left side of the screen) ▪ Select "Newsletters" from the drop down box ▪ Scroll down to CMS and select the volume (1 through 8) that you wish to read